Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PHYSICIANS SURGICAL CENTER
975 HASKELL STREET
FORT WORTH TX 76107

Respondent Name
TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-12-2579-01

MFDR Date Received
APRIL 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to T.D.I. Rule 134.402, Implants are to be reimbursed at the providers cost plus 10% interest up to $1000.00 per item or $2000.00 per case. The carrier ignored our request for payment of the implants and paid the claim @ 235%...At this time we are requesting your help in obtaining the payment we are owed."

Requestor's Supplemental Position Summary dated August 7, 2012: "The carrier did make an additional payment of $342.10 in April, but our disputed amount was $1,065.79. We are still owed $723.69 by the carrier."

Amount in Dispute: $723.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With the supplemental reimbursed now issued, the Carrier contends the Provider is not entitled to additional reimbursement."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 15, 2011	ASC Services for CPT Code 29888	-$2,757.72	-$2,757.73
	ASC Services for CPT Code 29881	-$464.35	-$463.52
	ASC Services for CPT Code 29882-59	-$464.35	-$463.52
	ASC Services for HCPCS Code L8699	$4,752.21	$4,752.21
TOTAL		$1,065.79	$1,065.79
Less Additional Payment of $342.10		$723.69	$723.69

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1-Workers compensation state fee schedule adjustment.
   - FEES-Reimbursement based on max allowable fee for this procedure based on medical fee schedule, or if on is not specified, UCR for this zip code area.
   - N9TX-Payment is based on the agreement entered between the provider and carrier before or during pre-authorization.
   - INCD-Included in global reimbursement.
   - P25N-W3-Additional payment made on appeal/reconsideration. Through a review of original payment and additional information received, it has been determined original invoice was processed incorrectly which resulted in this add'l payment.

Issues

1. Did the respondent make an overpayment for code 29888?
2. Did the respondent make an overpayment for code 29881?
3. Did the respondent make an overpayment for code 29882-59?
4. Is the requestor entitled to additional reimbursement for HCPCS code L8699?

Findings

1. 28 Texas Administrative Code §134.402(f)(1) states that reimbursement for non-device intensive procedures shall be "(A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

   CPT code 29888 is defined as "Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction."

   According to Addendum AA, CPT code 29888 is a non-device intensive procedure.

   Based upon the submitted documentation, the requestor sought separate reimbursement for the implantables; therefore the DWC conversion factor is 153%.

   The Medicare fully implemented ASC reimbursement for code 29888 CY 2011 is $3,447.64.

   The CMS City Wage Index for Fort Worth, Texas is 0.9474.

   To determine the geographically adjusted Medicare ASC reimbursement for code 29888:

   The Medicare fully implemented ASC reimbursement rate of $3,447.64 is divided by 2 = $1,723.82.

   This number multiplied by the City Wage Index is $1,723.82 X 0.9474 = $1,633.14.

   Add these two together $1,723.82 + $1,633.14 = $3,356.96.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153%

   $3,356.96 X 153% = $5,136.14.

The respondent paid $ 7,888.87. The difference between the MAR and amount paid is $2,752.73.

The respondent made an overpayment of $2,752.73 for CPT code 29888.

2. CPT code 29881 is defined as "Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed."

   According to Addendum AA, CPT code 29881 is a non-device intensive procedure and is subject to multiple procedure discounting.

   The Medicare fully implemented ASC reimbursement for code 29881 CY 2011 is $1,161.03

   To determine the geographically adjusted Medicare ASC reimbursement for code 29881:

   The Medicare fully implemented ASC reimbursement rate of $1,161.03 is divided by 2 = $580.51

   This number multiplied by the City Wage Index is $580.51 X 0.9474 = $549.97.

   Add these two together $580.51 + $549.97 = $1,130.48.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153%

   $1,130.48 X 153% = $1,729.63. Because it is subject to multiple procedure discounting, this number is multiplied by 50% $1,729.63 X 50% = $864.81.

   The respondent paid $ 1,328.33. The difference between the MAR and amount paid is $463.52.

   The respondent made an overpayment of $463.52 for CPT code 29881.

3. CPT code 29882 is defined as "Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)."

   According to Addendum AA, CPT code 29882 is a non-device intensive procedure and is subject to multiple procedure discounting.

   The Medicare fully implemented ASC reimbursement for code 29882 CY 2011 is $1,161.03

   To determine the geographically adjusted Medicare ASC reimbursement for code 29882:

   The Medicare fully implemented ASC reimbursement rate of $1,161.03 is divided by 2 = $580.51

   This number multiplied by the City Wage Index is $580.51 X 0.9474 = $549.97.

   Add these two together $580.51 + $549.97 = $1,130.48.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153%

   $1,130.48 X 153% = $1,729.63. Because it is subject to multiple procedure discounting, this number is multiplied by 50% $1,729.63 X 50% = $864.81.

   The respondent paid $ 1,328.33. The difference between the MAR and amount paid is $463.52.

   The respondent made an overpayment of $463.52 for CPT code 29882.

4. HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

   28 Texas Administrative Code §134.402(b)(5) states "'Implantable' means an object or device that is surgically:
   (A) implanted,
   (B) embedded,
   (C) inserted,
   (D) or otherwise applied, and
   (E) related equipment necessary to operate, program, and recharge the implantable."

   28 Texas Administrative Code §134.402(f)(1)(B)(i) states " the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

The Division finds the total allowable for the implants is:

IMPLANT DESCRIPTION	COST	DWC ALLOWABLE 28 Texas Administrative Code §134.402(f)(1)(B)(i)	TOTAL ALLOWABLE
Patellar Hemi	$2,950.00	$295.00	$3,245.00
Rigid btb cross pin kit	$400.00	$40.00	$440.00
ACL disposables kit	$467.00	$46.70	$513.70
Meniscal repair system	$311.00	$31.10	$342.10
Milagro interference screw	$390.00	$39.00	$429.00
Meniscal replacement	$197.00	$19.70	$216.70
TOTAL	$4,715.00	$471.50	$5,186.50

The total allowable for HCPCS code L8699 is $5,186.50. The respondent paid $434.29. The difference between the total allowable and amount paid is $4,752.21. This amount is recommended for reimbursement for HCPCS code L8699.

The Division finds that the difference between total allowable and amount paid is $1,067.44 [$4,752.21 minus overpayment of $3,684.77 ($2,757.73 + $463.52 + $463.52)].

The requestor originally sought dispute resolution for a lesser amount of $1,065.79. After the additional payment of $342.10 was issued, the requestor adjusted the amount in dispute to $723.69. As a result, reimbursement of $723.69 is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $723.69.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $723.69 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	05/30/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.